only for the American taxpayers but for the men and women who are serving so bravely in Iraq, and this is such a long overdue issue, as the gentleman mentioned, I helped write this bill but this came about after two Congresses of my own bill, the Iraq War Funding Accountability Act, that in the last Congress, as you know, was a Blue Dog-endorsed measure. That was an attempt to bring about accountability in Iraq in regard to the moneys that are spent by contractors in the reconstruction areas taking place in Iraq.

Unfortunately, we were not allowed under the last Congress or the last majority to bring this measure forward so we could debate it, so we could discuss it, so we could vote on it. But fortunately, with the new leadership in Congress, this has become an issue that has not only been discussed and debated but an issue that is going to be included in the bill that we have before us this week. And it's just so long overdue on the part of the American taxpayers and the men and women who are serving who, because this money is misspent, misdirected, sometimes lost, are going without the equipment that they need.

Every Member in this House has heard from family members and friends about their loved ones serving in Iraq who require supplies purchased by family members and friends and sent to them, everything from boots to protective gear, to the proper sunglasses, to supplies. It's absolutely inappropriate, and as long as we continue to misappropriate money and allow this to fall into the area of waste, fraud and abuse, and in sometimes criminal neglect or criminal negligence, this issue is only going to be exacerbated and the stories are just far too numerous.

We've heard the little stories that, in fact, some of these contractors are selling soda pop at $45 a case to the men and women who are serving in Iraq to the same contractors who are charging $100 to do a 15-pound bag of laundry, to the bigger issue, such as trucks, trucks that are burned in place because there's minor repair problems needed, to even bigger issues such as pallets of money, I think it was $12 billion that just disappeared in Iraq. And we have been trying to get a handle on this for a long time, and every effort that we have made has been short-stopped in this Congress, and finally, we are going to be able to get it out.

Mr. Speaker, I have here a Special Inspector General for Iraq Reconstruction Report. This is a report that's issued quarterly to Congress.

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It tells us very, very little about what's happening. It will tell us by contractor name how much we are obligated to them. It will tell us by contractor name how much they have expended. It will tell us by contractor name the percentage of increase in these expenditures, but it doesn't tell us how the contract was let, why the contract was necessary, and, if, in fact, the work being done was, in fact, completed.

This report represents a snapshot from 30,000 feet, no attempt at all to drill down and find the answers that the taxpayers and the servicemembers deserve. I have another report here about the construction by a contractor of the Baghdad police academy, obviously built in Baghdad. These pictures are worth 1,000 words. They show the fact that the work was done, shoddy workmanship. They show, in fact, that the supplies that were used by these contractors were inappropriate supplies, faulty, substandard supplies. This isn't pointed out in the quarterly report.

These are the things that we need to know, and I am just proud to be a member of the Blue Dogs who exist for one reason and one reason only, the one common thread that runs through the entire Blue Dog organization, and that's fiscal responsibility. It's fiscally irresponsible to continue to ignore these very real problems. It's fiscally improper to adopt this measure, to insist on accountability by those who are being paid just gross sums of money to do, in some instances, inappropriate, ineffective, substandard work.

I thank the gentleman from Arkansas for yielding, and I appreciate your leadership in helping get this measure signed into law and bringing accountability to these outrageous incidents that are taking place in Iraq today.

Mr. ROSS. I thank the gentleman from California for his work within the fiscally conservative Democratic Blue Dog Coalition to write and craft this Iraq war accountability bill known as House Resolution 97.

In the remaining 3 minutes or so we have left, I am going to yield to my friend, fellow Blue Dog member from the State of Georgia, Mr. DAVID SCOTT.

Mr. SCOTT of Georgia. Thank you, Mr. ROSS.

I will try to sum up what we have done this evening. It is very important, as the American people have followed this process, have seen us with the legislative process at work, not only in terms of debating the issue, but they have also witnessed how we are putting this, hopefully, this final piece together that the President will sign.

First of all, just to wrap up, we have made concessions with the President on the issues that he was concerned about. The timelines, have, indeed, been removed. Those were his major objections on it. So we have compromised on that point.

But we also had, then, accountability, and that's what the American people want. They want to make sure that we have accountability in this. Mr. THOMPSON from California has played a very leading role in this, and it was so good to have him on the floor talking about it. Mr. IKE SKELTON, who is the chairman of our Armed Services Committee, has incorporated all of the major points of financial accountability to get out fraud and waste, to bring in the Defense Department's investigators to report to us on each of these areas, on a 6-month basis, to show us how the money is being spent.

All of those things are now in this package, and the benchmarks are in, the benchmarks. So we can hold the Iraqi people to, and say, these are things that must be accomplished, as we go forward. If you don't hold their feet to the fire, if you don't put pressure there, there is no accountability. So we are going to have them on security.

We are going to have them where they are going to reach the deal of how, which is at the bottom of the whole situation, is oil, and how they are to divide the oil revenue between the Kurds, between the Sunnis and between the Shias. We have got this in there for benchmarks.

The other thing we have in there is funds for the troops, the Humvee protection, the body armor production. Never again will they go in Humvees and have to write back to mom and dad to give them the metals. They are over there fighting for the United States of America. It is our constitutional responsibility as the Congress of the United States to raise and support the military. That's in article 1, section 6 of the Constitution for our duty. This Congress is able to do that in this.

Finally, what is so important, we are having in this measure true emergency measures like the children's health program, in which we have $349 million now for that shortfall to help with the SCHIP program, for that lower-income program.

Many of those children, incidentally, Mr. ROSS, are children of some of these servicemen who are serving in Iraq, because their income level falls too low for Medicaid, yet not high enough to be able to afford the regular practice. The money is in here for the veterans to make sure the Walter Reed situation doesn't happen again. That's what's so important. That's what the American people want.

In this measure we have got that, and then plus $2.4 billion more than what the President asks for the troops. But we have got the accountability in, and it's geared to moving us in a way to get us out of the crosshairs of this civil war and in this occupation in Iraq so that we can strengthen our military and put the resources in Afghanistan and Pakistan where we know al Qaeda is and allow the Iraqi people to manifest themselves and solve this civil war among themselves.

Thank you. It has been wonderful being with you and being a part of our Blue Dog coalition this evening.

DELIVERY OF HEALTH CARE IN THE UNITED STATES

The SPEAKER pro tempore (Mr. SIRES). Under the Speaker's announced policy of January 18, 2007, the gentleman from Texas (Mr. BURGESS) is recognized for 60 minutes.

Mr. BURGESS. Mr. Speaker, I want to come to the floor tonight and continue on a theme that we were discussing last night, and that theme revolves around delivery of health care in this country.

Some of the discussion last night dealt with the future of medical care in this country, whether we expand the public sector involvement, whether we encourage and continue the private sector involvement in the delivery of health care in this country; and those are extremely important questions, and questions that I suspect that this Congress will be debating at length over the coming 18 months and well into the next Congress, the 111th Congress that convenes in 2009.

If we don't pay attention to the physician workforce that is going to be providing that health care, those discussions may be all for naught. We are obligated, in this Congress, to pay attention to access for our patients, patients in Medicare. You heard reference to the SCHIP program; patients in the SCHIP program are all going to need access to physicians. It doesn't matter whether a patient is a participant in the Medicare system, the SCHIP system, private insurance, pays cash for their care, they need access to a doctor, and that access will be unavailable if we don't preserve and protect our physician workforce going forward.

This really came home to me about a year and a half ago in a conversation with Alan Greenspan. He commented on the concern for the future viability and stability of the Medicare program, of the system as a whole, is it ultimately sustainable. He felt that it would be. But his greater concern was is there going to be anyone there to deliver the services when you require them? Of course, he is talking about our physician workforce, our nursing workforce, the ancillary health care personnel, all of whom we depend upon to deliver health care in this country.

We have an overburgeoning and overregulated governmental system that continues to sort of move along. We have got the other aspect of ever-increasing liability costs. If we have time tonight, I do want to touch on that just a little bit.

But not just the cost of medical liability insurance, but also the aggravation of dealing with a system that, on its face, sets doctors and patients against each other. We do have to deal with that.

The consequence of this is we have physicians who are my age who are leaving the profession early, earlier than the generation before them. It was very common for a physician to practice into their 60s and 70s and not at all uncommon to continue to read about physicians who continue to practice right up until the time that they no longer could.

You don't see that as much any more. Physicians are making plans to leave the practice of medicine at an earlier point now than, I believe, ever before in our Nation's history. At the same time, at the other end, are we having any problems filling our residency programs? The answer is yes.

Are we, in fact, encouraging the young people of this country to look upon health care as a career, as a profession? The answer to that question may not be affirmative either.

So we have got an increasing number of physicians who are making early retirement plans. We are not sure it's difficult to measure the number, but it doesn't seem that the younger generation is showing up in the numbers that we would expect. Both of those pose a significant concern nationally, because we have got a society that's aging. We have a society with the so-called baby boom generation coming up, and the demand for services is going to be ever-increasing during that time.

Suffice it to say, whether it's, again, the Medicare, SCHIP program, Medicaid, private insurance, cash on the barrel head, patients are going to need doctors; and it is incumbent upon this Congress to make certain that we do the things necessary to preserve the physician workforce in this country. The patients who need care, maybe a patient is in a city, or they may be a patient in a rural area, they may be a patient in an area that has been devastated by gulf coast hurricanes in the past couple of years. The reasons are complex, and we debate them at some length up here in Washington in the various ways that we can seek to improve our health care system.

But even as we engage in these issue, our physician workforce is crumbling. In order to keep this scenario from becoming worse, I am proposing a series of physician workforce pieces of legislation that will consist, essentially, of three different parts.

I would just draw your attention to the cover of Texas Medicine. This is a periodical put out by the Texas Medical Association every month. This is the cover of the March issue. The title is, ''Running Out of Doctors: Medical Schools Unable to Keep Residents in Texas.'' This is one of the things that we really do have to focus on.

When you look at the Medicare system, one of the biggest problems we have is the formula under which physicians are paid, and addressing the declining Medicare physician payment issue has almost become an annual rite here in Washington, DC. But every time we do that, we actually make it harder to ultimately reform the system. Every time we come in at the end game, at the end of the year, to try to prevent further cuts to the physician reimbursement system and the Medicare system, we actually make the overall solution to that problem harder and harder. The chance, then, for real reform, the opportunities for real reform, become smaller and smaller with each succeeding year.

The current payment system in the Medicare system, the current payment system rewards ordering labs and performing procedures, necessary or not. In fact, not often are the questions asked, if those services, not even if they are necessary, but are they, perhaps, overvalued. Is Medicare getting its best value for its dollar?

The current system is indifferent to the fact that the procedures or the tests ordered may be questionable or may have significant merit, may, in fact, be critical for a patient's well-being. The fact is that the system doesn't work. It doesn't work for doctors, it doesn't work for patients, and certainly not working for the American taxpayer. Yet, year in and year out, Congress allows it to persist.

Well, if we continue to allow this condition to stagnate, there will be fewer and fewer physicians accepting Medicare payments. This will result in reduced access for beneficiaries and a restriction in the physician workforce pipeline over a period when the demand for medical service is projected to explode.

Fewer students are pursuing a career in medicine. More and more doctors are retiring early. Even fewer will choose primary care fields in their study of medicine, and all of this happens against a backdrop of more and more Americans growing older. As Americans grow older, they do face greater and greater health challenges. So, arguably, our sickest and most complex patients are going to need to rely on an ever-dwindling physician workforce.

Now, if, indeed, we do nothing, the picture I have just painted may, indeed, become a reality.

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But again, the three pieces of legislation that I plan to introduce will start with one that will ensure stability of the physician work force by ensuring stability of the payment system within Medicare. There is a formula under which physicians are paid in Medicare, and I'm going to talk about this in a little bit more detail in just a few minutes, but it's called the sustainable growth rate. And the net effect of the sustainable growth rate formula is really anything but growth. It, in fact, results in a reduction over time, 5 to 10 percent reduction in physician payments year in and year out. And that number is brought to us every year by the Center for Medicare and Medicaid Services out of the Department of Health and Human Services. We'll actually receive data on that, what that number of that percentage cut will be this summer, sometime in July.

The first bill that I'm proposing would, in fact, eliminate that sustainable growth rate formula and replace it with a different formula. It's called the Medicare Economic Index, really not so important what it's called, but it is a cost of living update, if you will, a market basket update based upon the cost of input. What does it cost the doctor to run their office, to run their practice? And if they're going to be

able to sustain that over time, obviously, the Medicare reimbursement rates are going to have to keep up with the cost of living adjustment, or keep up with inflation. It only makes sense. We do it in almost every other aspect of Medicare. And again, I want to discuss that in some detail in just a moment.

One of the other things that happened in 2003 was we reset the SGR baseline to reduce the level of those cuts, and, in fact, that's a budgetary maneuver that may well be available to us again this year and, in fact, is one that I think we should take advantage of.

So this legislation does, in addition to repealing the SGR, it does so in the year 2010. In the 2 years prior to that time, reset the baseline so that the depth of those cuts are not so significant. In order to protect physician practices against a reduction in income and, hence, encouraging physicians to leave the Medicare system, in order to protect during that 2 years time, allow bonus payment of 3 percent for voluntary reporting on quality measures and 3 percent for those practices that choose to increase or improve their health information technology that almost every practice will be relying on with greater and greater need in the years to come.

So in aggregate, those bonus payments are 6 percent. And by resetting the baseline, the reduction in payment will be in the 5 percent range. So the net effect will be either a 0 percent update or possibly even a 1 percent update, which I think would be welcomed by most physicians in practice. And that's a temporary situation.

What is the reason to delay the SGR repeal? Why not just do it straight up? The reason is because of the projected cost by the Congressional Budget Office, and that projected cost makes it almost impossible to do that without making some significant adjustments in other aspects of payments for medical care that, quite frankly, I don't know that Congress has the will to do.

But the reality is, we are saving money year over year in Medicare by providing services in a more timely fashion. The Medicare prescription drug benefit passed in 2003, a case in point. The trustees, the Medicare trustees report released just a few weeks ago said that in 2005 there were 600,000 hospital beds that weren't filled in Medicare. This was a savings to part A in Medicare, which really should accrue to part B and go to offset the cost of repealing the SGR formula.

We are not allowed, under the rules of the Congressional Budget Office, we are not allowed to look ahead and say well, we are going to get savings in this system because of changes that we've made. But what we can do is sequester and aggregate those savings over the next 2 years, and then use those actual dollars to buy down or reduce the amount of dollars that it's going to cost to repeal the SGR.

Again, a small bonus update for beginning in the year 2008 for some health information technology implementation. These measures are in a large part well overdue. And this Congress, the last Congress was unable to come to an agreement, the House and the Senate, over the type of health information technology that we wanted doctors offices to pursue.

But the reality is, delaying that implementation further only tends to cost more money to the system. So we do need to get on about the business of encouraging physicians' offices to do this work. Not only is it necessary, I think, to provide that bonus payment, but it's also necessary to provide some safe harbor provisions in laws that are known as the Stark clause, the anti-kickback, and anti-compete laws that we know in aggregate as Stark 1 and Stark 2.

Additionally, if physicians voluntarily report quality data, that additional bonus payment will be there for them as well. So collect an aggregate. All of that data within the Center for Medicare and Medicaid services, money to save from part A, part C and part D as well. Aggregate, sequester those savings and use that to offset the cost of the ultimate repeal of the SGR.

And in addition to that, there is the Inspector General in Health and Human Services, along with the Department of Justice, have gotten very aggressive about going after areas where health care monies are spent inappropriately, the so-called fraud and abuse that exists within some aspects of the Medicare system.

And a recent newspaper article disclosed a significant amount of money that was recovered by eliminating an episode of fraud and abuse that was occurring I believe in the State of Florida.

Well, those monies need to be, again, reallocated back to the part B part of Medicare again to pay down or buy down the cost of that SGR appeal when the time comes.

Now, one of the issues that was addressed in the Texas Medical Association article is that because of the lack of residency programs within the State of Texas, Texas is doing a good job with, they've expanded medical schools and they're doing a good job with medical instruction, but the doctors that they're educating in Texas are having to leave Texas to get their specialty training or their residency training. And the fact is that most physicians practice within 100 miles of where they did their residency training. So to be able to increase the amount of residency programs that are available in rural areas, in midsize or small urban areas, it is going to take some effort by this Congress for that to happen.

The United States does have good residency programs. They're the envy of the world, and people come from all over the world to participate in our postgraduate education in our academic medical centers. But that's just the point. A lot of residencies do exist in conjunction with large academic medical centers and, as of a consequence, that's in a large urban area.

Again, doctors are more likely to practice close to where they train and in similar environments. So most American trained doctors, as you would imagine, stay in urban areas and practice specialty or subspecialty medicine, which is not a bad thing. And that's not to say that that is necessarily wrong, but we do need more physicians who are going to set up their practices in primary care in more of the generalist theme rather than the specialty theme.

The second bill that would be introduced would be the Physician Work Force and Graduate Education Enhancement Act. And it establishes an interest free loan program for eligible hospitals in rural, small and urban areas to attract residency programs in specialties like family medicine, internal medicine, pediatrics, emergency medicine, OB/GYN or general surgery. This would require an authorization of $25 million over 10 years from 2008 to 2018. And of course the Secretary of HHS would report back to Congress on how the program is doing with achieving its stated goals.

Well, let me talk for just a moment about the Medicare payment formula, because this is an important point, and it is difficult to understand. It's a program that obviously was created by Congress and Federal agencies and one that is understandable by perhaps very few.

But looking at this graph, the colored bars on this graph represent the years, 2002, 2003, 2004, 2005, 2006, I'm sorry, 2007, 2006 does not appear on this graph because it was actually a 0 percent, 2006 is the blue bar on the graph.

If you look at the four parts of Medicare, the hospitals representing Medicare part A, doctors, Medicare part B, Medicare Advantage, part C, including nursing homes on this graph as well, and you look at the Medicare Advantage plans, the hospitals and the nursing homes, and each of those year over year receive a market basket or a cost of living upgrade year over year. You can see for hospitals, for example, it's ranged about 3 percent a year, sometimes a little bit lower, sometimes a little bit higher. The Medicare Advantage plans have done a little bit better. Nursing homes very similar to hospitals.

But look over at the physician reimbursement. In the year 2002 there was about a 4½ percent reduction in physician reimbursement. Then, in 2003, 2004, 2005, very, very modest, 1.8, 1.7 percent cost of living updates. Lower, I would point out, than hospitals, nursing homes or certainly the Medicare Advantage plans.

In 2005, this was actually part of the Deficit Reduction Act that was passed in 2005 and held physicians at a 0 percent update.

Projection for 2007 was for a significant reduction, but the reality was,

again, we made an adjustment at the end of last year to once again hold that at a 0 percent update.

But you would have to ask yourself, how long, at running a small business, could you continue without any attention being paid to what does it cost to run the business? At some point, if this line stays flat or continues to diminish, at some point you don't have to have an MBA from an elite Eastern institution to figure out that you cannot continue to sustain that. Again, physician offices, in the main, are small businesses and as a consequence, a continued reduction in payment or even a flattening of payment which when everyone else is seeing a cost of living adjustment of between 2 and 4 percent, that's indicative of the inflation rate for medical offices. And they in fact are on a significant downward trajectory, one that ultimately is not likely to be sustainable.

Now, last year, in an attempt to deal with this, I introduced legislation that was a little bit different from the bill that I've introduced this year. It was H.R. 5866, and it was aimed at tackling this problem with the sustainable growth rate formula and replacing it with a cost of living update, a cost of living adjustment update. The primary focus was to ensure that seniors have better access to the health care that they need, that, acknowledging that the SGR reductions of 5 percent every year, year over year, makes it less likely for doctors to continue to see Medicare patients.

The plan then had four main goals. Ensure that physicians receive a full and fair payment for services rendered; secondly, to create quality performance measures to keep consumers informed. Are you, in fact, getting value for your dollar when you purchase medical care. We have well established, in fact, they've been around for 20 years or so, institutions in each State called quality improvement organizations.

Well, I wanted to, in fact, embellish or augment the quality improvement organizations and increase their accountability and flexibility so that they would be able to provide the feedback to physicians and to patients as to how they are doing; are they able to provide the services for a reasonable amount of money? Are they able to provide the services in a timely fashion? Do they provide the services that people in fact want?

Well, the problem with 5866 is that once again there was a significant number of dollars that would need to be identified to offset the cost of going from the sustainable growth rate formula to the cost of living update formula. That figure last year was about $218 billion. And that is a significant amount of money to come up with over 1 year's time. Hence, the reason that this year the trajectory that I have introduced has lengthened that timeline out a little bit longer in order to identify where some of those pay fors may be found.

The other option, following along the lines of 5866 from last year, would just simply be to take the money from other aspects of Medicare and other parts of the Federal payment for health care in this country. The problem is that each of those areas finds great difficulty if indeed a proposal is made to restrict or reduce the Federal expenditures that come their way and, as a consequence, 5866 never enjoyed very widespread support because of the fact that, like so many things here in Washington, DC, you end up having to pick winners and losers.

□ 1845

That is the reason that I have taken the approach that I have for this year to expand out the timeline for the elimination of the SGR, to identify pay-fors in advance that are going to be going on anyway, but we just simply sequester them, collect them, attribute them to the part B part of Medicare. Savings that occur in hospitals, if you fill 600,000 hospital beds a year fewer than was intended, that is going to be a significant savings to the part A part of Medicare. But the reality is that savings occurs because of work that is done in part B. More doctors doing more procedures in their offices, doctors treating disease in a timely fashion so that fewer hospitalizations are required, doctors doing procedures in ambulatory care centers so that the high expense item of a hospital expenditure is, therefore, avoided. But all of those expenses come back to part B. It is only fair, then, that the savings that result to the system, the integrated Medicare system, those savings that come to the Medicare system, need to be attributed to the part B, especially when we have got this large price tag for repealing the SGR that confronts us.

Well, again, this year I want to approach things a little differently. But, again, first and foremost if you are talking about preserving the physician workforce, you have got to protect those men and women who are on the ground, in the trenches, delivering care right now. If they get dispirited and walk off the job or say, I am no longer going to care for Medicare patients or I am going to restrict Medicare patients from my practice or begin restricting the procedures that I offer to Medicare patients, we don't get good value for our dollar that way.

So getting that Medicare payment policy right has to be the first aspect of this physicians workforce consortium that will preserve our medical workforce for the future. Paying physicians fairly will extend the careers of many doctors who otherwise will simply opt out of the Medicare program or seek early retirement.

The principles of the new bill: Again, eliminate the SGR. It is critical that the SGR be eliminated, and we can't lose sight of that fact. The problem is right now I don't think there is the savings identified to eliminate the SGR nor am I convinced that the will in Congress is to eliminate the SGR in one chunk. So extend that timeline out a little bit and allow that price tag to be reduced because of the lengthening of the timeline. But eliminating the SGR is the fundamental principle that has to be followed, and the bill that I am going to introduce will eliminate the SGR in the year 2010 and in the meantime provide incentive payments based on quality reporting, technology improvement that could total as much as 6 percent to protect the physicians over these next 2 years where the cuts in the SGR arguably will be about 5 percent.

In both 2008 and 2009, physicians' practices can opt to take advantages of those bonuses and may, in fact, be returning value back to their businesses, and this would be a good thing. If you expand the ability to monitor patient care through health information technology, that is not just for your Medicare patients. That is going to be for all patients. So there would be a general improvement that would permeate throughout a physician's practice. Most physicians in this country don't just see Medicare or don't just see Medicaid. In fact, they see a mix of patients, some Medicare and some Medicaid, some private insurance; but all patients under a doctor's care would benefit from the advances in health information technology.

Let me digress for just a moment and talk a little bit about health information technology because I was a late arrival to the concept of the necessity of improving health information technology, but it really came home to me in October of 2005 when I took a trip to New Orleans. I was invited by several of the hospitals down there to come down to see how their doctors were coping with the after effects of the storm, see what had happened to some of the physical infrastructure. We spent part of the afternoon in Charity Hospital in downtown New Orleans. Charity Hospital, one of the venerable old training hospitals that has been around for generations. In fact, most of my professors at Parkland Hospital had trained a generation before at Charity Hospital in New Orleans.

And here is a picture of the medical records department in Charity Hospital in October of 2005. Katrina, as you recall, came through right at the end of August of 2005. It doesn't show up well, but there is still probably three or four inches of water on the floor. Like many hospitals, Charity's medical records department was in their basement.

The lights that you see overhead were actually pretty dim. I was able to get a good photograph because of a television crew that was following along behind us with their very bright lights. But look at the medical records, and you can see the black mold that has grown on these because of, again, the water on the floor and probably 110 percent humidity in this hot, damp basement. The records had been flooded.

And then after the water had been mostly evacuated, of course, the water damage has already happened and now you have the growth of the black mold on the records. And, really, I don't think anyone would be too interested in handling those records.

And even if you just look at the overall arrangement of this medical records department, you can see some records stuffed in on their sides up there. Some others have fallen down over there. It just makes you wonder about how good this paper system is if everything goes well. And if things go badly, as you can see, they can go very badly indeed.

Well, another aspect that clarified in my mind the importance in upgrades of health information technology, a couple of months ago, of course, when all of the newspaper stories were going on out at Walter Reed Hospital, I took a trip out there to visit with the soldiers and see for myself firsthand what the situation was in Building 18. And, correct, Building 18 was an old building and it really wasn't that nice. And I think we are all better served by the fact that our soldiers who are on medical hold are no longer being housed in Building 18.

But the bigger problem, Master Sergeant Blade was kind enough to explain to me what he saw as a greater degree of difficulty for our soldiers who were on medical hold waiting to see if they could rejoin their units or if they were going to be discharged from the service on a disability. And you see this rather large stack of papers that he has in front of him. That is his medical record. He is going through it with a yellow highlighter to make his case in regards to a particular disability claim. And his largest concern was, after spending hour after hour after hour going through his medical record and documenting the points that he thought were critical for him to receive the proper consideration from the Disability Board, he said it wasn't uncommon for that medical record to go sit on someone's desk for a couple of weeks and then ultimately be lost. So he was advising the men in his unit. In fact, I think it was either the second or third copy of his medical record that he was marking up in this manner so that he wouldn't run the risk of putting all his time and effort into documenting the issues surrounding his disability only to have the medical record disappear because the system really wasn't well suited to handle that.

And that really brought home for me the fact that, well, of course, the VA system has a relatively forward thinking electronic medical record, but the problem is the record produced by the Department of Defense doesn't talk to the VA record system, and as a consequence, the poor soldier in the middle has to spend the time and the effort going through their individual record to make certain that, again, their case gets the proper disability consideration that it deserves.

So just two reasons why I have become a believer in the past couple years that improving the information technology aspect of medical practice, true in hospitals but also true in physicians' offices as well, why I have become a believer that that is, indeed, something we do need to be devoting time and resources to. There are certainly problems with some of the systems that are out there, but ultimately the payoff is going to be that we will be able to deliver care faster, cheaper, smarter, and as a consequence, deliver more care and more value for our patients.

One of the other things that again I think is important in this endeavor and the reason I have included part of the bonus payment for quality reporting is that you can't change a system if you don't know what is going on within the system. Now, again, I would stress that this would be voluntary quality reporting, that no physician or physician's office would be required to provide quality reporting. The risk to run there is that the SGR reduction would affect that physician's bottom line in 2008 and 2009. But if a physician or medical practice opted not to do quality reporting or improvements of health information technology, beginning in the year 2010, they would indeed see a repeal of the SGR, replacing that with the Medicare Economic Index. So beginning a series of positive updates of about 2 to 2½ percent in the year 2010, but, again, to forestall the pain that would go on in the years 2008 and 2009, reset that SGR baseline so the cuts are not so deep, and then provide protection for voluntary reporting measures on quality, voluntary improvements in an office's health information technology, and make these things so that they are generally available, which CMS would be tasked with making the quality reporting measures generally available, and really sort of zero in on the top 10 conditions or diagnoses where the bulk of the money is spent in the Medicare system. Not so much to emphasize quality reporting measures for esoteric diseases or diseases that are encountered once in a career but those things that are encountered over and over and over again: hypertension, diabetes, congestive heart failure. These are the types of things where the concentration of dollars is going to be located, and these are the areas where the quality reporting really needs to be focused.

The part of the issue there is that the quality reporting measures do have to be generally available to physicians in all specialties and all practices. We certainly don't want to see someone who is not able to participate because their particular specialty does not have an identified quality reporting mechanism. CMS and some of the specialty organizations are already pretty far down the road on this, and really at this point it has not been identified to me that there is a problem or would be a problem for a particular specialty with not having a mechanism to report quality.

Well, dealing with the other aspects of the physician workforce, the other two aspects of the three pieces of legislation, one would deal with physicians in residency and one would deal with those individuals who are looking to become physicians or those individuals who are in medical school.

The Physician Workforce Graduate Medical Education Enhancement Act of 2007 would acknowledge that it is costly to educate medical students and it is costly to get medical students through a residency program. The big programs are in more heavily populated areas that tend to attract more residencies, but we need to get the physicians out into the smaller and rural communities where the medically underserved populations actually exist and get them out there in high-needs specialties. So developing a program that would permit hospitals that do not traditionally operate a residency training program would be the second aspect of establishing and protecting the future physician workforce. So this bill would create a loan fund available to hospitals to create residency training programs where none have operated in the past. And, again, that is a critical aspect to this. This is not something that is to go in and layer on top of existing programs, but this would be to create residency programs where none has existed previously. Communities like the community of Denton, Texas, that I represent, a community like the community of Lewisville, Texas, that I represent, smaller community hospitals, 150 to 200 beds, no residency program has ever existed in those communities. These would be the types of targeted communities that perhaps we could look to for establishing residencies in primary care, OB/GYN, pediatrics, general surgery.

□ 1900

On average, it cost $100,000 a year to train a resident, and that cost for some institutions can be prohibitive. In addition, the Balanced Budget amendment, passed 10 years ago in this Congress, has a residency cap that limits resources to hospitals, such as smaller community hospitals. The loan amounts available under this bill would not exceed $1 million, and the loan would constitute start-up funding, again, for new residency programs.

The start-up money is essential. Since medical graduate, medical education funding can be obtained only once a residency program is established, the cost to start a training program for a smaller, more rural and/or small urban hospital can be cost prohibitive because these hospitals do operate on much narrower margins.

Identifying high-need physician specialties and getting young people to consider medical school, to getting young medical students to consider going into a primary care specialty, to going into one of those medically underserved areas, again, going back to the Texas Medical Association article,

the Texas Medicine article, most physicians practice close by where they did their residency. And as a consequence, there are areas in the country that do lack medical care by trained professionals. So the third aspect of this three-part health workforce, physician workforce trio of bills, the third part would ensure the availability of the adequacy of the future physician workforce in providing medical students with incentives and assistance to practice in shortage areas and shortage specialties in those shortage areas.

So the third bill would be to establish a mix of scholarships, loan repayment funds, and tax incentives to entice more students into medical school in the first place, and then create incentives for those students, those newly minted doctors, to become the family physicians, the general surgeons, the OB/GYNs, the pediatricians, the gerontologists, to become those practitioners of the future that are going to more likely stay in shortage areas, such as rural and small urban areas.

There is no question that the issues in front of us as far as the physician workforce are serious, they are significant. But the feeling is that once you have established measures that will allow the medical workforce of the future, then you can begin to refine other aspects of the health care system. And, again, as I stressed last night, we are going to have that tension between what is public and what is private. What is paid for by the government, what is paid for by insurance, what is paid for by people who wish to pay cash. Is it better to have a health savings account or rely on SCHIP or Medicaid? Those arguments we are going to have, but those arguments are going to diminish in importance if we don't do the things necessary to create and retain the physician workforce that is going to be necessary to take care of people in the future.

One of the greatest frustrations that I hear all the time from medical professionals, and since we are on the subject of medical professionals and how to keep physicians engaged in practicing medicine and how to get more people to consider health care as a career, obviously medical liability plays a big part in that. My home State of Texas has done an excellent job of dealing with the medical liability issue. We, on the floor of this House in Congress, in fact for the last two Congresses over the previous 4 years have passed several medical liability bills that have had at their heart a cap on noneconomic damages patterned after the Medical Injury Compensation Reform Act of 1975 out in California that has been so effective in keeping the cost of providing liability insurance within reason.

Now, my home State of Texas, the year that I ran for Congress the first time in 2002, was in a crisis situation. We were losing insurers from the State liability. Insurers were leaving Texas because the climate was so pernicious. Rates were going up for physicians. For those companies that stayed behind, their rates were going up, doubling and sometimes tripling.

The State of Texas and the State legislature passed a bill in the summer of 2003 that actually again was patterned after that Medical Injury Compensation Reform Act of 1975 out in California that capped noneconomic damages. The Texas approach was a little different from the approach that we took in Congress. The approach we took in Congress had a $250,000 flat cap for noneconomic damages. The Texas solution actually took that cap and spread it out three ways; a $250,000 cap for the physician, a $250,000 cap for the hospital and a $250,000 cap for a nursing home or a second hospital, if indeed there was a second hospital involved. That required a constitutional amendment in order to become law. And that constitutional amendment was passed in September of 2003. It was not passed by a very large margin. It was essentially the grass-roots efforts of physicians, their families and their patients that got the constitutional amendment passed that allowed the Texas law to take effect.

But the effect of the Texas law over the ensuing 3 or 4 years has been significant. Medical liability premiums have now fallen 20–22 percent. My last insurer of record, Texas Liability Trust, has reduced insurance rates by 20 to 22 percent, depending upon the length of time that the doctor has been with the company.

More importantly, insurance companies have come back, liability carriers have come back to the State of Texas. We diminished from about 17 carriers to 2 in 2002. Now there are 13 or 14 carriers back in the State. And most importantly, they have come back to the State without an overall increase in their premiums.

One of the big beneficiaries of the law that was passed in Texas has been the smaller community-based not-for-profit hospital. The money that they were previously having to—these hospitals largely self-insured and the dollars that they were having to put in escrow against possible claims was significant. And now these hospitals have been able to put more of that capital back to work for them: capital expansions, hiring nurses, paying nurses' salaries. Exactly the kinds of things you would want your smaller community hospitals to be able to do they have now been able to do under the legislation passed in Texas.

Well, if Texas is in such good shape from its liability reform, is it still important to consider passing a law at this level, at the Federal level, to deal with our medical justice system? And the answer still is yes. Legislation in draft form that I had scored by the Congressional Budget Office right before we did our Republican budget a few months ago, at the request of the Budget Committee ranking member, we put forth that legislation, the Congressional Budget Office scored it as savings of $3 billion over 5 years. Well, we are already talking about other areas in the Federal expenditure of health care funds where that money is needed. And that $3 billion, in fact, it's wrong, it is unconscionable to leave that money on the table and not provide that money to other areas of the Federal expenditure for health care where it might come in handy.

And the bigger aspect for me, the more important aspect for me in dealing with the problem of the medical justice system at the Federal level is the dollars that are spent on defensive medicine in the Medicare system, in the Medicaid system. A study from 1996, so that is 10 years ago, over 10 years ago, out in Stanford, California, estimated the cost of defensive medicine in the Medicare system, just in the Medicare system, not in the entire health care system, but just in the Medicare system, amounted to about $28 billion a year. Again, that is money we can scarcely afford to leave on the table. If those savings are available to us, indeed, we do need to be getting those dollars back.

But it is not just a dollars-and-cents issue. Nome, Alaska. I happened to be through there in the summer of 2003, stopping in Nome, Alaska, with a group of other Congressmen. You can imagine the Chamber of Commerce wanted to have a big lunch, so they invited us all there. And of course being a physician who was also a Member of Congress, about the entire medical staff from their hospital, all 19 physicians turned out to talk to me during the course of our stopover in Nome, Alaska. And one of the points that they wanted made was that they needed help because they couldn't afford the medical liability cost for having an anesthesiologist in their hospital. And the doctor who was telling me this story, I asked, well, what is your specialty, sir? And he said, well, I am an OB/GYN doctor just like you. And I said wait a minute, you're an OB/GYN doctor and you work in a hospital that doesn't provide anesthesia services. How do you do that? Ignore for a moment the woman who may need an epidural during child birth, what do you do if you're faced with having to do a C-section? He said, well, we get that patient and put her on an airplane and take her to Anchorage. Anchorage, probably 3 hours away. I am given to understand that they sometimes have bad weather in Nome, Alaska. It just makes no sense that we would allow a system like that to continue. We are doing nothing to enhance patient safety; we are doing nothing to enhance the ability to deliver care by allowing a system like that to continue.

Again, we are talking about the workforce issues. Talking to a residency director from one of the large residencies up in New York City a couple of years ago, I asked her what effect the medical liability problem was

having on attracting young physicians into their residency program. And she replied to me that we are now taking people into our residency program that 5 years ago we wouldn't even have interviewed. So these are our children's doctors. We are driving away some of the best and brightest from the desirability of the practice of health care, and we need to do better.

So once again I would add that, while the three bills that will establish and encourage and protect and preserve and defend the existing physician workforce and the physician workforce of the future in this country, we also need to pay attention to the medical justice system in this country.

We have had a number of hearings in my committee, the Committee on Energy and Commerce, and our health subcommittee on this issue. There are some other suggestions out there in addition to or instead of the caps on noneconomic damages. I am willing to listen to other philosophies, but the reality is in my home State of Texas. Caps on noneconomic damages again are working. They are delivering lower premium rates for physicians. They are delivering on the promise of more flexibility for capital expenditures for small community-size hospitals because of the dollars they don't have to tie up in escrow because of the way their self-insurance plans are constructed.

And, again, we've seen the insurance companies come back to Texas. And I do from time to time hear people say, well, it's just the insurance companies wanting to make more money. The reality is, my old insurer in Texas was a physician-owned company, a physician-run company. It was essentially a company where all of the profits were returned back to the insurance company. We have several of those in Texas. So I don't believe it is all just a question of a profit-driven motive from the liability insurer.

One of the things that I think we lose sight of, and there was an article in one of the papers today that talked about the fact that America was not the premier as far as the delivery of health care. We can have a lot of arguments around that thought, around that philosophy. The American health care system in general, and certainly the Medicare program in particular, has no shortage of critics here at home and certainly abroad. But it is the American system that stands at the forefront of innovation and new technology, precisely the types of system-wide changes that are going to be necessary to efficiently and effectively provide care for Americans, and particularly for America's seniors in the future.

There was an article, and please don't tell anyone back in my home State of Texas that I read the New York Times, but there was a New York Times article published last October, October 5, by Tyler Cowan who writes: When it comes to medical innovation, the United States is the world leader. In the past 10 years, for instance, 12 Nobel Prizes in medicine have gone to American-born scientists working in the United States, three have gone to foreign-born scientists working in the United States, and seven have gone to researchers outside of the country.

□ 1915

He goes on to point out that five of the six most important medical innovations in the past 25 years have been developed within and because of the American system.

The fact is the United States is not Europe. American patients are accustomed to wide choices when it comes to hospitals, wide choices when it comes to physicians, and choices in their pharmaceuticals. Because our experience is unique and different from other countries, this difference should be acknowledged and certainly expanded when reforming either the public or the private aspect of healthcare delivery in this country.

Mr. Speaker, in the time that I have remaining, let me just recap again the three aspects of physician workforce that I am going to be introducing.

This will be a bill to repeal the so-called sustainable growth rate expenditure and replace that with a Medicare Economic Index or cost of living index for physicians beginning in the year 2010; protections in the year 2008 and 2009 for voluntary reporting and voluntary compliance with improvements in health information technology.

The second bill will deal with the physician workforce and graduate medical education. This will establish an interest-free loan program for eligible hospitals in rural and small urban areas to establish residency training programs for primary care, family medicine, internal medicine, pediatrics, emergency medicine, general surgeon and OB/GYN. The authorization for this will be $25 million over 10 years, those 10 years being 2008 through 2018 inclusive. Of course, the Secretary of HHS will report to Congress on the efficacy of the programs and how they are going about achieving their stated goals.

Finally, and interestingly enough, we voted on a bill on the floor of this House just a few hours ago that would be a loan forgiveness package for lawyers who graduate from law school with large student loans and are willing to practice as prosecutors in high need areas. This would be a very similar structured bill that would establish a scholarship program for physicians who are wanting to practice in primary care in high need areas to alleviate shortages in the fields of family medicine, internal medicine, pediatrics, emergency medicine, general surgeon and OB/GYN, again the so-called generalist physicians.

This authorization would be for $5 million for each of 5 years, fiscal year 2008 through 2015, a $25 million total authorization that would establish a loan repayment program for generalist physicians who agree to serve in medically underserved areas. A second authorization for an additional $25 million total would make grants to States to provide financial aid to physicians agreeing to serve in medically underserved areas and to support patient-centered coordinated care in qualified medical homes.

There would be additional authorizations to make grants for board certified entities to establish or expand geriatric program fellowships in rural, suburban or medically underserved communities, and, finally, a report to Congress on the efficacy of the program.

Then lastly, but certainly not least, amend the Internal Revenue Code so that gross income does not include compensation received by a physician from a local government for a qualified medical service that is performed in a medically underserved community and under contract with the local government for 4 years. This compensation will be taken into account as wages and must still be reported, but it just won't count toward that individual's adjusted gross income.

Mr. Speaker, I appreciate very much the time allotted to me this evening. These are important issues. Again, whether one comes down on the side of increased governmental control of medical care or continuation of some aspect of the private practice of medicine in this country, the critical thing is that we have the doctors there who are willing and able and trained to provide the services that we all want.

Additionally, for those individuals who would say expansion of the government program, the government-funded side of medical care is the only way to adequately cover people in this country, I think we have to look at how good a job we are doing right now with about the 50 percent that is devoted to the public sector in the practice of medicine. About 50 cents out of every health care dollar spent in this country has as part of its origin the United States Congress at some point or other.

So we have to ask ourselves, are we doing a good enough job there? And I would suggest, particularly when you look at things like the sustainable growth rate formula under which physicians are paid, I think the answer to that question would have to be no, we can do a better job with that.

So certainly before any consideration for expanding any part of the public part of paying for medical care in this country, we have got to be sure that we have our figures straight. We have to be certain that we are willing to tackle the tough problems of paying for those things, and certainly the SGR formula needs to be sunsetted and needs to be no longer part of the parlance and discussion on the floor of this House of Representatives.

CERTIFICATION REGARDING EXPORT OF CERTAIN ITEMS TO THE PEOPLE'S REPUBLIC OF CHINA—MESSAGE FROM THE PRESIDENT OF THE UNITED STATES (H. DOC. NO. 110–34)

The SPEAKER pro tempore laid before the House the following message from the President of the United States; which was read and, together with the accompanying papers, without objection, referred to the Committee on Foreign Affairs and ordered to be printed:

To the Congress of the United States:

In accordance with the provisions of section 1512 of the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999 (Public Law 105–261), I hereby certify that the export to the People's Republic of China of the following items is not detrimental to the U.S. space launch industry, and that the material and equipment, including any indirect technical benefit that could be derived from such exports, will not measurably improve the missile or space launch capabilities of the People's Republic of China:

A four-axis filament winding machine for production of spare parts for China's water purification and treatment industries;

A computer control system upgrade to a three-axis filament winding machine for production of spare parts for China's water purification and treatment industries;

An isostatic press for manufacturing automotive spare parts; and

A four-axis filament winding machine to be used in production of graphite or glass composite golf clubs.

GEORGE W. BUSH.

THE WHITE HOUSE, *May 15, 2007.*

RESIGNATION AS MEMBER OF COMMITTEE ON THE BUDGET AND COMMITTEE ON FOREIGN AFFAIRS

The SPEAKER pro tempore laid before the House the following resignation as a member of the Committee on the Budget and the Committee on Foreign Affairs:

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, May 15, 2007.

Hon. NANCY PELOSI,
House of Representatives, Office of the Speaker, Washington, DC.

DEAR SPEAKER PELOSI: In light of my election to the Committee on Financial Services through passage of H. Res. 393 and pursuant to House Republican Conference rules regarding service on certain standing committees, I am compelled to and do hereby resign from service on the following committees: Committee on the Budget and the Committee on Foreign Affairs.

Sincerely,

THADDEUS G. MCCOTTER,
Member of Congress.

The SPEAKER pro tempore. Without objection, the resignation is accepted.

There was no objection.

VOTE BY HOUSE ON WHETHER TO GO TO WAR WITH IRAN IS NEEDED NOW

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Washington (Mr. MCDERMOTT) is recognized for 5 minutes.

Mr. MCDERMOTT. Mr. Speaker, we need a vote on whether this country is going to go to war with Iran. We have talked to the Speaker about it. She has promised it. But the time is getting short. Every day that we wait, we allow people down at the White House to continue to talk about this.

The vote we gave in 2002 to allow the President to deal with the problems of 9/11 was not a blank check to attack any country in the world. This war on terror began with some sense in Afghanistan, and then moved to Iraq to the absolute chaos we have today. It is a quagmire from which we can't get ourselves. And, unfortunately, the President and his Vice President are leading us, it appears, toward a war with Iran.

Ask why the urgency? Why do you want to come out here and talk about that tonight? Well, there was an article that appeared today in the Al-Quds Al-Arabi, which is an Arabic paper published in London. It is a very respectable paper, and it is one that most people in this body, in fact most people in this country, never heard of, nor do they understand and will never know about it because our press won't pick it up.

But I read the Middle Eastern press every day. I have some in my office who read Arabic, and they translate it for me, and I get a summary every day in my office of what is going on. This article I think deserves to be quoted a little bit, because people may not get the Congressional Quarterly or the CONGRESSIONAL RECORD and read it.

The article says this: ''Vice President Dick Cheney yesterday ended his tour of the Arab world that started with Iraq and ended in the capitals of four other Arab countries, Egypt, Jordan, Saudi Arabia and the United Arab Emirates. High ranking Arab diplomatic sources close to the talks with Cheney confirmed to the newspaper that the probability of war became more likely than peace in the region.''

This is Arabs listening to the Vice President of the United States talk.

''The same sources indicated that Cheney was talking to Gulf leaders he met in a very confident and self-assured way, stressing that the involvement of this country in Iraq does not mean it is in a weak situation and cannot launch another war.''

Think about that. The Vice President is telling the Arab leaders, because we are in this mess in Iraq, just ignore that. We still can go to Iran and have a war.

Cheney went and talked to soldiers and sailors on one of the aircraft carriers, ''announcing to them,'' and this again is a quote, ''in a decisive manner that the U.S. will not allow Iran to possess nuclear weapons and that the option of a military attack is not excluded.''

Now, he said, again quoting, ''Cheney expressed his conviction that striking Iran may be the best solution for the situation in Iraq.''

Think about it. We are going to solve our problems in Iraq by attacking Iran. He says, ''because Tehran,'' the capital of Iran, ''has the biggest influence in the country and is the source of the arms of the militia.''

Now, this is from a man who sent to Iraq a guy named Bremer who took down all the guards and all the barriers at the border between Iran and Iraq, and Iran, of course, has been coming into Iraq. This administration set it up, or else they were ignorant. You can take your choice on that.

He said, ''They do not expect that there will be any retaliation by Iraq's Shiite militias. Quite the contrary, the Sunni groups and militias will take the opportunity to settle accounts with the ruling government in Baghdad under American support.''

So what he is saying is that the United States is shifting its support from the Maliki government, which is Shiite, and they are now over there telling people, well, we are going to now be supporting the Sunni elements so that they can get—Mr. Speaker, I include the translation of the Al-Quds Al-Arabi article for the RECORD.

Vice-President Dick Cheney yesterday ended his tour of the Arab world that started with Iraq and included the capitals of four other Arab countries, Egypt, Jordan, Saudi Arabia, and the United Arab Emirates, amidst a war of words with the Iranian President Ahamdi Nijad, who launched a diplomatic counter-attack in the form of two sudden visits to the Emirates and to Oman.

High-ranking Arab diplomatic sources close to the talks with Cheney confirmed to Al-Quds Al-Arabi that the probability of war became more likely than peace in the region after the round of meetings of the vice-president, and that the expected meetings between the Iranian and American sides in Baghdad might be the last chance to avoid military confrontation.

The same sources indicated that Cheney was talking to Gulf leaders he met in a very confident and self-assured tone, stressing that the involvement of his country in Iraq does not mean that it is in a weak situation and cannot launch another war, against Iran. Cheney, who visited the troops of his country in Iraq and the Gulf during his last round, made sure that he met American soldiers on an airplane carrier announcing to them in a decisive manner that the US will not allow Iran to possess nuclear weapons, and that the option of a military attack is not excluded. The Iranian President replied against that with severe threats in a press conference in Abu Dhabi, assuring that if they (Americans) make that mistake, the reply of Iran will be very strong and they will regret it. [Amedinejad said] ''All the world knows that they cannot beat us and Iran is capable of defending herself, and that the superpowers cannot stop us from possessing nuclear energy.''

It was observed that Gulf states have begun searching for alternatives to the Gulf straits to export their oil abroad. There were suggestions to build pipelines to the Red Sea